Sample 837 Scenarios

The sample scenarios are for test and education purposes. The information is test data and does not represent actual insurance carriers, employers, injured employees, or health care providers. The information may appear to be real or confidential information. However, this is done in order to ensure the test data passes validation edits.

TX 837 - Scenario 4

Request for Reconsideration / Additional Payment Made

Darlene Davidson is a single female, born 06/04/69. She lives at 5720 Green Drive in Arlington, TX 62309. Her telephone number is (703) 836-5527 and her social security number is 224-17-3272.

Darlene works at Bagels, Etc. located at 234 Main Street in Arlington, TX 62314. Bagel, Etc.'s telephone number is (703) 472-1462.

Bagels, Etc. is insured by WorkComp Insurance Company, covered under policy number 147643A472. WorkComp Insurance Company is located at 789 Airport Road in Dallas, TX 60606-1234. Their telephone number is (312) 555-1470 and their FEIN is 98-7654321.

- On 02/26/04 Darlene fell and fractured a rib on the job at Bagels, Etc.
- On 10/23/04 she went to Make Me Well Clinic for an impairment rating exam. She was examined by Dr. Robert Smudge, license MDD0432TX.
- On 10/23/04 Make Me Well Clinic submitted an original bill for services performed with the following charges:
 - o DOS 10/23/04; 99456-WP; 1 unit; \$800.00
 - o DOS 10/23/04; 99080-69; 1 unit; \$15.00
- On 11/05/04 WorkComp Insurance Company received the bill.
- On 12/11/04 WorkComp Insurance Company mailed payment to the provider in the amount of \$300.00:
 - o \$300.00 paid using ARC W1 to indicate payment for 99456-WP
 - \$0.00 paid using ARC W1 and B15 for 99080-69.
- On 12/17/04 WorkComp Insurance Company sent a transaction to TWCC covering a reporting period of 12/10/04-12/17/04 that included the IC unique bill/invoice number 123456.

Scenario 4

- On 12/14/04 Make Me Well Clinic sent a Request for Reconsideration that included a copy of the original bill and an explanation for the request.
- On 12/17/04 WorkComp Insurance Company received the Request for Reconsideration from Make Me Well Clinic.
- On 1/08/05 WorkComp Insurance Company sent a total payment of \$500.33 to Make Me Well clinic.
 - \$500.00 supplemental payment for CPT code 99456-WP with ARC W3
 - \$.33 interest payment (included on the EOB)
- On 01/09/05 WorkComp Insurance Company sent a transaction to TWCC, covering a reporting period of 01/02/05-01/09/05 that included the IC unique bill/invoice number 456789 without indication of the \$.33 interest payment (the 837 does not support interest payment reporting).

PLEASE DO NOT STAPLE IN THIS AREA

WorkComp Insurance Company 789 Airport Road Austin, TX 60606-1234

PICA		SURANCE CLAIM	FORM	PICA
1. MEDICARE MEDICAID CHAMPUS CHAMP	VA GROUP FECA OTHER HEALTH PLAN BLK LUNG	1a. INSURED'S I.D. NUMBER	(FOR PROGRA	AM IN ITEM 1)
(Medicare #) (Medicaid #) (Sponsor's SSN) (VA Fil	e #) (SSN or ID) (SSN) (ID)	224-17-3272		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
Darlene Davidson	06 04 69 M FX	Bagels, Etc.		
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)		
720 Green Drive	Self Spouse Child Other X	234 Main St.		
CITY STAT	E 8. PATIENT STATUS	CITY		STATE
Arlington TX Single Married Other		Arlington		
ZIP CODE TELEPHONE (Include Area Code)			ZIP CODE TELEPHONE (INCLUDE AREA CODE)	
09 (703) 836-5527 Employed X Full-Time Student Student		62314 (703)472-1462		52
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER		
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS)	a. INSURED'S DATE OF BIRTH SEX		
	YES NO	MM DD YY		F
O. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)			
MM DD YY	YES NO	D. EMI ESTETIS NAME ON SOFIOCE NAME		
E EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME		
S. E. C. ETTO HAME OT OUT OF HAME	YES NO	C. INSCRANCE FLAN NAME OR PROGRAM NAME		
J. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	A 10 THERE ANOTHER HEALTH RENEFIT OF ANO		
. INSURANCE FLAN NAME OR PROGRAM NAME	TOU. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?		
		YES NO If yes, return to and complete item 9 a-d.		
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for		
to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		services described below.		
USION.				
SIGNED DATE		SIGNED		
14. DATE OF CURRENT: ILLNESS (First symptom) OR MM DD YY INJURY (Accident) OR GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY		
02 26 04 PREGNANCY(LMP)		FROM TO		
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 17a. I.D. NUMBER OF REFERRING PHYSICIAN		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM , DD , YY		
		FROM TO		
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES		
		YES NO		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.		
1 807 01		ONG WAE HET . NO.		
1. 607. 01		23. PRIOR AUTHORIZATION NUMBER		
2	4.1			
4. A B C	D E	F G	HIJ	K
	PURES, SERVICES, OR SUPPLIES plain Unusual Circumstances) DIAGNOSIS	DAYS E	amily nec	SERVED FOR
MM DD YY MM DD YY Service Service CPT/HC		\$ CHARGES UNITS		OCAL USE
0 23 04 10 23 04 11 9945	6 WP 1	800 00 1		
0 23 04 10 23 04 11 9908	0 69 1	15 00 1		
			-	
SE FEDERAL TAY ID AUDIED	ACCOUNT NO. OT ACCEPT ACCIONING	00 70741 211725		
	S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE \$ 815 00 \$		
435621987 X YES NO			\$	i
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33. PHYSICIAN'S, SUPPLIER'S I & PHONE #	BILLING NAME, ADDRESS,	ZIP CODE
(I certify that the statements on the reverse Molro Mo. Wolf		Make Me Well		
apply to this bill and are made a part thereof.) Robert Smudge MDD0432TX 345 Lower Level		345 Lower Level		
12/14/2004 Arlington, TX 62308		Arlington, TX 62308		
SIGNED DATE		PIN# GRP#		